



Transcription translates to patient risk

Issue:

Traditional transcription methods and the use of voice or speech recognition technology (SRT) for health care documentation have put patients at risk for injury and death. In one case related to SRT, a medical malpractice claim yielded the seventh-largest jury verdict for 2012, when a jury awarded \$140 million in punitive damages to a patient's family. The patient, a lifelong diabetic, was admitted to a hospital when she developed a blood clot in her dialysis port. Upon discharge, she went to a rehabilitation facility. A nurse at the hospital transferred the patient's information to the rehabilitation hospital. Instead of obtaining the medication reconciliation document and the patient transfer order, the nurse obtained the information she needed from a copy of the doctor's dictated discharge summary, which had been sent out of the United States for transcription. The transcription contained errors, including a notation that the patient was to receive 80 units of insulin instead of eight. At the rehabilitation hospital, the patient received an incorrect dosage, which caused brain damage, cardiopulmonary arrest and death.¹

While SRT has many benefits, its vulnerabilities can lead to tragic outcomes, as the case above illustrates. Some of the concerns about current documentation practices include: improper use and expectations of SRT capabilities; mismanagement of SRT with degradation of translation accuracy over time; no standards for style, grammar and readability; minimal standards for certification, continued education or professional development of transcriptionists; and unclear roles and standards for editors of transcribed medical notes.

In addition, there are insufficient comprehensive quality assurance and process improvement programs for health care documentation. The result is lack of accountability, minimal regulatory oversight, and almost no monitoring of documentation processes. These issues were apparent in the illustrative case, in which a U.S.-based health care documentation company subcontracted work via its international arm; this off-shore transcription of health care documentation occurred without the knowledge of the physician. The reason for the subcontract was the cost of transcription. The plaintiff in the case argued that "cheap transcription" translated to poor quality transcription.

Surveys show that critical error rates for speech recognition proofreading and editing are as high as 22 percent.² It has been found that voice recognition takes 50 percent longer to dictate and there are 5.1 errors per case. Additionally, 90 percent of all voice recognition dictations contained errors prior to physician sign off. After sign off, 35 percent of voice recognition still had errors.³ It has been found that human factors contribute to the inaccuracy of speech recognition documentation errors, including voice accent and tone, which may affect the translation of the speech recognition into the medical record.

Additionally, a recent study concluded that the physician-as-editor model does not guarantee that error will be found, and that physicians do not always take the time to edit and proofread the transcribed medical record.⁴ Health care documentation companies also use disclaimers to point out the problems with SRT that can result in a patient safety event. One example of a disclaimer reported to The Joint Commission is: *"Portions of the record may have been created with voice recognition software. Occasional wrong-word or*

Examples of critical health care documentation errors

- Dictated: This 92-year old female did well surgically and was sent to the ICU secondary to cardiomyopathy and age.
Transcribed: This 92-year old female did well surgically and was sent to the ICU secondary to cardiomyopathy and AIDS.
- Dictated: The patient is on 40 mg of Lasix.
Transcribed: The patient is on 400 mg of Lasix.
- Dictated: He had no episodes of unconsciousness en route.
Transcribed: He had episodes of unconsciousness en route. (Omitted no)
- Dictated: Amaryl 4 mg b.i.d.
Transcribed: Amaryl 4 mg t.i.d.

Reproduced from Healthcare Documentation Quality Assessment and Management Best Practices, July 2010⁵

(Cont.)



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The intent of *Quick Safety* is to raise awareness and to be helpful to Joint Commission-accredited organizations.
The information in this publication is derived from actual events that occur in health care.

'sound-a-like' substitutions may have occurred due to the inherent limitations of voice recognition software. Read the chart carefully and recognize, using context, where substitutions have occurred."

According to health care documentation expert Laura Bryan, MT (ASCP), CHDS, AHDI-F, quality documentation is everyone's job. "A culture of respect combined with a continuous quality improvement program that involves every step of the voice-to-text process – including enforcing dictation best practices, monitoring audio quality, maintaining all aspects of the technology – and a nonpunitive quality assurance program focused on edification, are necessary to achieve the quality and accuracy required for medicolegal documents." Bryan represents the Association for Healthcare Documentation Integrity (AHDI) on the Health Information and Management Systems Society (HIMSS) Health Story Project Leadership Council. She has served on AHDI's board of directors and contributed to AHDI's Book of Style.

Safety Actions to Consider:

Ongoing quality assessment (QA) in health care documentation and the use of best practices are critical to the delivery of safe patient care and the avoidance of patient harm related to transcription. The following recommendations for improvement are from the health care documentation industry.⁵

Apply the principles of quality in implementing the quality program for the documentation process. The actual process of implementing the quality program can be specific to each organization but the application of the principles of quality should be at the core of the program.

- Establish an adequate QA budget for personnel, resources, software, and continuing education. Three percent of the total departmental budget is offered as a suggested starting point.
- Establish quality assessment policies and procedures in each facility. Distribute policies and procedures to all documentation authors and transcription staff. Establish facility specifications and maintain databases of pertinent, facility-specific information.
- Train the quality assessment staff in the computation methods described in the *Healthcare Documentation Quality Assessment and Management Best Practices*,⁵ and promote consistency and objectivity among the editing staff. In particular, acknowledge and encourage development of critical thinking skills, continued education in the definition and application of the quality standards, and successful mentoring skills.
- Establish a feedback mechanism for authors and medical transcriptionists (MTs) that is education-based. Errors should be identified within their context. Track improvements following intervention and map any trends.
- Follow guidelines for appropriate intervals for quality assessments.
- Compile results of the QA review findings and provide reporting as needed by various departments or stakeholders at prescribed intervals.
- Provide ongoing staff development, especially in areas where quality issues are identified.

Assess specific and unique factors that affect the outcome of the documentation process, including workflow, turnaround time, and technology.

- Establish practical workflow procedures in the author-to-text process so that accuracy and turnaround times are achievable.
- In the transcription portion of the workflow, allow for 100 percent concurrent review of entry-level, newly hired, or cross-training MTs, and concurrent review of flagged reports.
- Establish workflow procedures for routine assessment of the recommended baseline of 1 percent random review for MTs and authors who are not under 100 percent review. If possible, reviews should be performed concurrently. Perform retrospective reviews if necessary to achieve established turnaround times.

Encourage medical records/transcription departments to have continuous quality improvement (CQI) processes in place like other hospital departments in which the quality and appropriateness of services is defined and measured with the aim to:

- Identify problems and continually improve processes
- Establish proofreading requirements
- Establish an educational process and feedback mechanism for dictators to improve dictation quality



- Address the use of outsourcing and offshoring
- Encourage the use of AHDI's Book of Style (or other book of style) for medical transcription
- Develop guidelines for implementing dictator style preferences, and better understanding of technology (e.g., electronic health record (EHR) interfaces, cell phone usage)
- Establish guidelines for handling discrepancies, blanks, and the inappropriate use of verbatim transcription
- Establish policies and procedures for monitoring quality of documentation produced by clinicians using free-text entry via keyboard or speech recognition



Report health care documentation events that impact patient safety to The Joint Commission for a comprehensive systematic analysis, corrective action plan and a plan to measure improvement. See the [Sentinel Event policy and procedures](#) for more information.⁶

Resources:

1. Alabama Law Weekly (ISSN 1063-2603) (USPS 22591), published by M. Lee Smith Publishers®
2. Quint LE, Quint DJ, Myles JD: Frequency and spectrum of errors in final radiology reports generated with automatic speech recognition technology, *Journal of the American College of Radiology*, 2008;5(12), 1196–9. doi:10.1016/j.jacr.2008.07.005
3. Pezzullo JA, Tung GA, Rogg JM, Davis LM, Brody JM, and Mayo-Smith WW: Voice recognition dictation: Radiologist as transcriptionist. *Journal of Digital Imaging*, 2008;21(4), 384–9. doi:10.1007/s10278-007-9039-2
4. David GC, Chand D, and Sankaranarayanan B: Error rates in physician dictation: Quality assurance and medical record production. *International Journal of Health Care Quality Assurance*, 2014;27(2), 99–110. doi:10.1108/IJHCQA-06-2012-0056
5. Association for Healthcare Documentation Integrity (AHDI), Medical Transcription Industry Association (MTIA), and American Health Information Management Association (AHIMA): Healthcare Documentation Quality Assessment and Management Best Practices, July 2010. <http://www.ahdionline.org/LinkClick.aspx?fileticket=f3sQg96ixiQ%3D&tabid=601> (accessed April 14, 2015)
6. The Joint Commission: Safe use of health information technology, [Sentinel Event Alert #54](#), March 31, 2015 (accessed April 16, 2015)

Note: This is not an all-inclusive list.